Canada health and social transfer

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THE CANADA HEALTH AND SOCIAL TRANSFER: OPERATION AND POSSIBLE REPERCUSSIONS ON THE HEALTH CARE SECTOR

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THE CANADA HEALTH AND SOCIAL TRANSFER: OPERATION AND POSSIBLE REPERCUSSIONS ON THE HEALTH CARE SECTOR*

ISSUE DEFINITION

For over three decades, the federal government has used transfer payments to help the provinces carry out their responsibilities in terms of health, post-secondary education and public assistance. Before 1996-1997, transfers for health and post-secondary education were made under the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, generally referred to as Established Programs Financing (EPF), while transfers for welfare and social assistance services were made under the Canada Assistance Plan (CAP). Federal contributions to EPF and CAP were considerable. According to Department of Finance documents, EPF transfer payments amounted to $21.9 billion in 1995-1996, while transfers under CAP accounted for approximately $8 billion.

In 1995, the federal government decided to bring EPF and CAP together under a single financing mechanism: the Canada Health and Social Transfer (CHST). Bill C-76, which created the new block transfer, was assented to on 22 June 1995, and the CHST came into force in 1996-1997.

This paper will examine the overall operation of the new financing mechanism and will attempt to assess its possible repercussions, primarily in the health area. The first part of the paper will take a brief look at the background and operation of EPF and CAP and the second part will describe the nature and general operation of CHST. The third and last part will analyze the possible consequences of CHST for public finances at the provincial level, provincial health care expenditures and federal government enforcement of national health standards.

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* The original version of this Current Issue Review was published in September 1995; the paper has been regularly updated since that time.

BACKGROUND AND ANALYSIS

A. Transfers under EPF and CAP: Brief Background

Federal and provincial responsibilities for health, post-secondary education and public assistance are quite different. Under Canada's Constitution, health, education and social programs are primarily matters of provincial jurisdiction, and the provinces are responsible for their delivery. By invoking its "spending power," the federal government has intervened in those areas, leading to the making of federal transfer payments to the provinces. The transfers make it possible to redress the constitutional imbalance between provincial taxing powers, which are more limited than those of the federal government, and provincial responsibilities, which are often onerous. Federal transfers also improve fairness between the provinces in terms of the services offered to the public.

1. Established Programs Financing

The EPF, which came into force on 1 April 1977, was the largest federal transfer program to the provinces. Under the program, each province received an equal per capita transfer for health insurance (including hospitalization, medical care and extended health care services) and post-secondary education. About 70% of all EPF transfers were earmarked for the "health" component, while the remaining 30% went to the "education" component. This breakdown was arbitrary, because EPF was a "block" funding mechanism. This meant that EPF was not a shared-cost program with transfers determined on the basis of the provinces' own expenditures on health and education.

Originally, the basic payment under EPF was calculated on an initial amount, determined in 1975-1976, which was then adjusted each year, according to an escalator that took into consideration per capita rate of growth in the GDP. To determine the total value of a province's EPF entitlement, the initial amount was multiplied by the escalator and then by the population of that province.

The escalator has been modified on several occasions since the mid-eighties. In 1983-1984 and 1984-1985, the escalator associated with EPF education was capped at 6% and 5%

respectively (if the formula based on the growth in the GDP per capita had been used, EPF-education amounts would have increased by 9% in 1983-1984 and by 8% in 1984-1985). For all other years, the escalator for post-secondary education was the same as for health insurance. From 1986-1987 to 1989-1990, the escalator used to calculate total EPF payments was reduced by 2%. After this period, and until 1994-1995, per capita transfers were frozen at their 1989-1990 levels, so that the total amount of transfer payments increased only in accordance with population growth in each province (about 1%). For 1995-1996, the escalator was decreased by 3% and the result was a negative escalator (-1.0%, according to the Federal-Provincial Relations Division of the Department of Finance); this meant a decrease in transfers, given the fact that per capita GDP growth was less than 3%.

EPF transfers had two components, a tax transfer and a cash transfer. Cash transfers to the provinces are made periodically by cheque, while the federal government also accords a certain tax room to the provinces through the transfer of tax points. To do this, the federal government reduces its tax rates while the provinces increase their rates by an equivalent amount. This procedure results in a reallocation of revenue between the two levels of government: federal revenue is reduced by an amount equivalent to the increase in the provincial governments' revenues. The fiscal burden on taxpayers remains the same because, although they pay more provincial tax, they pay less federal tax.

Under EPF, the federal tax transfer was 13.5 tax points on individual income tax and one tax point on corporate tax. The provinces whose fiscal strength was lower than a provincial standard received equalization payments to bring their transfer up to that standard (the provinces making up the standard are Quebec, Ontario, Manitoba, Saskatchewan and British Columbia). The cash transfer corresponded to the difference between the total EPF entitlement of each province and the value of the tax transfer. As part of its opting-out agreements, Quebec received a special abatement of 8.5 additional tax points on personal income. Because of this additional abatement, Quebec received a relatively larger share of its federal contribution than the other provinces in the form of transferred tax points and a smaller share in the form of cash. In total, however, Quebec's per capita entitlement under EPF is exactly the same as those of other provinces.

The federal government does not impose any specific condition on the provinces respecting the proportion of transfers they must devote to post-secondary education. The provinces must, however, comply with the conditions and criteria set out in the *Canada Health Act* (CHA), or be subject to financial penalties. These conditions are universality, accessibility, comprehensiveness, portability and public administration. The Act also requires provinces not to impose user fees or allow extra-billing.

Until 1991-1992, penalties for failure to comply with the CHA were applied only against cash transfers for EPF-Health; however, since that time they have also been applied against other provincial entitlements. This extension of financial penalties to other entitlements was made necessary by the continual limitations placed on the growth rate of EPF transfers and the particular effects of such restrictions on the cash transfers; it was estimated that, if the $11 billion basic amount had not been established, EPF-Health cash transfers to some provinces would have reached zero by the end of the century.

2. The Canada Assistance Plan

CAP was created in 1966. It had two primary objectives with respect to persons in need: to assist the provinces to provide welfare services and social assistance and care in appropriate facilities and to ensure services in order to lessen, eliminate or prevent the causes and effects of poverty, child neglect and dependence on public assistance. The Plan had the following components:

> General Assistance: Assistance for meeting basic needs: food, accommodation, clothing and so on; the greater part of CAP expenditures.
>
> Special care facilities: Care provided to people living in old age homes, rest homes and other kinds of facilities defined in the agreements.
>
> Health care: Health costs such as medication and dental services not covered under provincial health care plans.
>
> Child protection: Cost of maintaining children placed in foster homes.

Welfare services: Child care, adoption, rehabilitation and community development.

Work adjustment programs: Projects for persons having difficulty in obtaining or keeping a job for personal or family reasons.

CAP was a shared-cost program: the federal government refunded approximately 50% of the eligible costs incurred by the provinces. The growth in contributions made under CAP thus varied directly with the provincial expenditures on public assistance. CAP involved cash transfers only, except in the case of Quebec, which received a special five-point tax abatement on personal income. Under the CAP agreements, the federal government set certain conditions. For example, the provinces had to include a right of appeal in their social assistance legislation and could not restrict eligibility by imposing a provincial residency requirement.

The provinces were responsible for the design, eligibility criteria and administration of public assistance programs. To obtain their share of funds, however, they had to prove that their programs and services met the Plan's requirements; provincial claims could be challenged if the federal government believed that the funds were spent in ways that did not meet the criteria set out in the agreements. For example, the Government of British Columbia decided to impose, starting on 1 December 1995, a three-month residence requirement before individuals could receive social assistance. That same month, the Honourable Lloyd Axworthy, federal Minister then responsible for CAP, announced that CAP transfer payments to British Columbia would be reduced by $47.1 million because that province had limited eligibility for this program.

From the beginning of the plan's operation until 1990-1992, CAP transfers were open-ended, that is, the federal government kept pace with whatever the provinces decided to spend and transfers were accordingly not subject to any limits. In 1990-1991, the federal government decided to place a ceiling on financing, usually called the "*cap on CAP.*" More specifically, a 5% limit for 1990-1991 and 1991-1992 was placed on annual increases in the contributions made to the three provinces that received no equalization payments (Alberta, British Columbia and Ontario); the other provinces were not subject to any limit. In February 1991, the federal government decided to extend the ceiling until 1994-1995. Then, in its February 1994 budget, for 1995-1996 it froze at their 1994-1995 levels the amounts paid under CAP to all provinces.

B. The Canada Health and Social Transfer: Its Nature and Operation

In the Budget Speech of February 1995, the federal government announced a new block transfer for EPF and CAP. According to budget documents, block funding awarded under CHST should give the provinces more discretion over how funds are to be divided among health, post-secondary education and public assistance. The *Budget Implementation Act, 1995* (Bill C-76), which was assented to on 22 June 1995, created the new transfer. The Act specifies the amount of the CHST and its breakdown by province. It also establishes the terms and conditions under which the new transfer would be paid in 1996-1997. **Bill C-31, the *Budget Implementation Act, 1996*, which received Royal Assent on 20 June 1996, established the terms and conditions for 1997-1998 through 2002-2003.**

Under this legislation, the amount of the CHST is $26.9 billion in 1996-1997, and $25.1 billion for each fiscal year from 1997-1998 through 1999-2000. For each subsequent fiscal year, through 2002-2003, the CHST will be based on GDP growth, as follows:

$CHST_t = CHST_{t-1} \times [\sqrt[3]{(GDP_{tc-1}/GDP_{tc-4})} - q]$, **where**

$CHST_t$	=	**amount of the CHST for the current fiscal year**
$CHST_{t-1}$	=	**amount of the CHST for the preceding fiscal year**
GDP_{tc-1}	=	**GDP for the calendar year ending in the immediately preceding fiscal year**
$t-1$	=	**fiscal year preceding the year to which the calculation applies**
$tc-1$	=	**calendar year ending in the immediately preceding fiscal year**
GDP_{tc-4}	=	**GDP for the calendar year ending in the fourth preceding fiscal year**
q	=	**a predetermined coefficient, equal to 0.020 in 2000-2001, 0.0150 in 2001-2002, and to 0.010 in 2002-2003**

Starting in 2000-2001, the CHST will be based on the preceding year's CHST, increased by a factor equal to the average GDP growth for the three preceding years less a predetermined coefficient (q). For example, if average GDP growth for the three calendar years preceding 2000-2001 is 3%, and the coefficient "q" for that year is 2%, the 2000-2001 CHST will be equal to the preceding year's CHST plus 1%.

The CHST is similar in structure to EPF: it includes a tax points transfer and a cash transfer. For 1996-1997 and 1997-1998, the CHST for each province is based exclusively on transfers received under CAP in 1994-1995 and under EPF in 1995-1996. For 1998-1999 through 2002-2003, the CHST for each province will gradually be based, partly, on the province's demographic weight within Canada as a whole. The CHST for each province is calculated as follows:

$CHST_{pt} = CHST_t \times [(q \times TRANSF_p/TRANSF) + (1-q) \times POP_{pt}/POP_t]$, where

$CHST_{pt}$	=	the CHST that province "p" may receive for fiscal year "t"
$CHST_t$	=	total CHST for fiscal year "t"
$TRANSF_p$	=	sum of transfers received by province "p" under CAP in 1994-1995 and under EPF in 1995-1996
TRANSF	=	sum of transfers received by all provinces under CAP in 1994-1995 and under EPF in 1995-1996
POP_{pt}	=	population of province "p" in fiscal year "t"
POP_t	=	population of all provinces in fiscal year "t"
q	=	a coefficient, with a value of 1.0 for 1996-1997 and 1997-1998, 0.9 for 1998-1999, 0.8 for 1999-2000, 0.7 for 2000-2001, 0.6 for 2001-2002, and 0.5 for 2002-2003

The cash transfer is calculated in the same way as was the case under EPF: the province's total CHST entitlement, less the tax points transfer. As before, the tax points transfer is 13.1 tax points on individual income tax and one tax point on corporate income tax. Quebec's additional abatement of 8.5 tax points on individual income tax remains and, as was previously the case, reduces the cash component of the transfer by an equivalent amount. However, the legislation provides that the total cash component of the CHST may not be less than $11 billion for 1998-1999 through 2002-2003.

As the following table shows, the transfers will be continuously reduced starting in 1995-1996 and will stabilize in 1997-1998. More specifically, total transfers will drop by approximately $4.5 billion from 1995-1996 to 1997-1998. The cash component of the transfers will be reduced even more, by approximately $6 billion over the same period.

TRANSFER PAYMENTS UNDER EPF, CAP AND CHST
1993-1994 to 2002-2003
($000,000)

	1993-1994	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002 2003
CAP	7,719	7,877	7,877	-	-	-	-	-	-	-
EPF	21,240	21,479	21,859	-	-	-	-	-	-	-
CHST	-	-	-	26,900	25,100	25,100	25,100	25,700	26,500	27,400
TOTAL	28,959	29,431	29,686	26,900	25,100	25,100	25,100	25,700	26,500	27,400
CASH	17,666	17,620	18,538	15,047	12,500	11,800	11,100	11,100	11,200	11,300

Source: Federal-Provincial Relations Division of the Department of Finance documents, March 1996.

As well, as was the case in the past, provinces whose fiscal strength is lower than the provincial standard receive equalization payments to bring their transfer payments up to that standard.

C. Consequences of the New CHST

The CHST does not distinguish among insured health services, extended health services, post-secondary education, social assistance programs and welfare services. However, the specific conditions set out in the *Canada Health Act* continue to apply to the delivery of insured health services by the provinces; in addition, these conditions will henceforth apply to all CHST cash contributions. Under the new transfer, the provinces are required, as they have been, to offer social assistance without imposing a minimum residency requirement; moreover, the cash contribution may be reduced or withheld if the prohibition against imposing residency periods as a condition of eligibility for provincial social assistance programs is not observed. Finally, the Act establishing the CHST provides that additional national standards could be imposed with respect to other provincial social programs.

The federal government's CHST, generally speaking, is not really an innovation. According to the Council of Canadians, the new transfer represents "a fundamental rollback of the modern welfare state in Canada." It follows the policy of restricting expenditures that was adopted

in the 1980s and allows the federal government to exercise a degree of "control" over national standards. The CHST does not suggest any new approaches to increasing the efficiency of Canada's health care system, even though, according to a number of observers, this lack of efficiency constitutes the main obstacle to maintaining a public health insurance system in Canada. Finally, the interim nature of CHST only serves to heighten the current uncertainty in the health sector.

The many modifications made by the federal government to EPF and CAP over the last decade have considerably affected the rate at which transfers to the provinces have grown and have accentuated the imbalance of public finances in some provinces. The limitation on the growth of transfers, in particular on EPF payments, has affected the provinces' financial ability to maintain their public health insurance plans. In addition, the new CHST systematically reduces the value of the federal transfers, which in the medium term may make it difficult to enforce national health standards.

However, the 1996 budget answered some questions that had been raised by the *Budget Implementation Act, 1995*. Stabilization of federal transfer payments, which should not be less than $25 billion until 2002-2003, gives the provinces quite a long time to plan in-depth reform of their health care systems. As well, by setting the basic amount of the total cash component at $11 billion, the federal government retains some degree of authority to ensure that national health care standards are met.

1. Provincial Public Finances and Provincial Expenditures for Health Care

The federal government's purpose in limiting transfers to the provinces is to reduce the deficit. The provinces do not agree with the government's methods. A number of provincial governments argue that the federal government restrictions are inappropriate because provincial entitlements did not cause the deficit. Some say that the federal government's attempt to balance its books by decreasing its contributions to the provinces only shifts costs from one level of government to another; it has no practical effect on the efficiency of either the programs offered or the management of the public purse. In addition, reductions in transfer payments will force the

provinces, who are grappling with their own deficits, to revise their priorities in order to compensate for the decrease in income from the federal government.

In order to maintain their level of expenditures in the area of health, the provinces must then choose between increasing their own deficits or increasing their revenues through a tax hike or perhaps through a premium to be paid by health service users. Alternatively, the provinces could decide to reduce the level of health services; most have already begun a de-insuring process. Ultimately, it is the taxpayer or recipient of the services who will have to bear the burden of the readjustment.

Because of the decrease in federal transfers, the have-not provinces will find it increasingly difficult to offer an extended range of health services to their citizens. The governments of such provinces are not in a position to pay an ever-growing share of health care costs from their own revenues.

Without the guaranteed basic amount of $11 billion, Quebec would have been in a special position. This province took advantage of an opting-out clause under EPF and CAP and requested an additional tax abatement. This abatement is similar to a transfer of tax points, except that the federal government does not grant Quebec additional tax room. Instead, this additional tax abatement replaces the cash transfer that the federal government would otherwise have had to pay out. In this regard, a 1994 federal government publication states:

> Since its inception, EPF legislation has treated the abatement as a substitute for cash payments. In light of this long-standing legislation and practice ...the abatement [is treated] as part of the EPF-PSE cash contribution.

The amount of the federal tax abatement granted to Quebec has therefore been subtracted from the cash transfers made to it. Accordingly, federal cash transfers are decreasing a great deal faster in Quebec than in the other provinces. **The value of the special abatement would quickly have exceeded the value of the cash component of the transfers.** Soon, the value of the special abatement will exceed the total of the cash transfers; in which case, for the CHST, as for the EPF, the federal government may claim a refund. **In its 1995 budget documents, the Quebec government estimated that it would have had to make refunds to the**

federal government starting in 1999-2000, which could well have complicated its efforts to put its public finances on a sound footing. The $11 billion basic amount guarantees Quebec cash components greater than its abatement, thus ensuring that future transfers are adequate.

The situation is becoming increasingly difficult for all provinces as health care costs continue to climb. At the federal-provincial-territorial Health Ministers meeting on 4 July 1995, in which the governments of Quebec and the Yukon did not participate, the federal Minister of Health, the Hon. Diane Marleau, had announced the federal government's intention to ensure the stability of its financial contributions to the provinces so that they could maintain their programs and health plans. However, she had not specified the level at which the transfers would be stabilized nor the means that would be employed to ensure the adequacy of future contributions. **The assurance of stable federal funding until 2002-2003, given in the 1996 budget, seems to have calmed the fears raised by the dramatic drop in federal transfers to health and social programs from 1995-1996 to 1997-1998.**

2. National Health Standards

As noted earlier, the *Canada Health Act* provides for financial penalties for provinces that do not comply with national standards or that allow extra-billing or user fees. On the coming into force of that Act in 1984-1985, and up to 1991-1992, the application of cash penalties in response to violations of the Act was limited to EPF-Health cash transfers; however, since 1992-1993, the penalties have been able to be applied to other provincial entitlements. Beginning in 1996-1997, these penalties affect the cash component of CHST transfers.

A number of analysts believed that, under the *Budget Implementation Act, 1995*, if the CHST were to be extended beyond 1997-1998 and the formula used to calculate it continued to be modelled on EPF, the cash component of the transfer would gradually disappear over the next decade. They said that the federal government's restrictions on transfer growth during the last decade and, beginning in 1996-1997, the net reduction in cash transfer payments for health and social programs were gradually undermining its ability to ensure compliance with the conditions and criteria of the CHA. These analysts said they did not understand how the federal government could continue to claim that it would be able to apply national standards effectively. As Banting and Boadway pointed out in their Presentation to the

Standing Committee on Finance, "declaring the inviolability of the *Canada Health Act* but then slowly abandoning the means of sustaining it is simply not a credible position." Others stated that the federal government's firm adherence to national standards in areas that are primarily under provincial jurisdiction, in conjunction with increasing funding reductions, might seriously compromise federal-provincial relations and make negotiations between the two levels of government more difficult and more strained.

Still others feared that, in the medium term, the provinces would no longer feel they should be subject to national standards; in view of the limitations on their revenue levels and the constantly increasing pressure on health expenditures, they would make substantial changes in their health insurance plans to suit themselves. The result could have been the dismantling of health insurance plans in this country, increased inter-provincial disparities in the level, quality and accessibility of care and an increase in the private sector delivery of health services.

To forestall the erosion of the public health insurance system in Canada, some proposed stable federal funding, with a permanent and predictable structure. According to Banting and Boadway, "the level at which the transfer should be stabilized ... would inevitably be a compromise between the need to reduce the federal deficit on one side and the need to retain sufficient cash to give credibility to federal sanctions on the other."

The 1996 budget seems to have calmed these fears. In the opinion of Ken Battle, President of the Caledon Institute of Social Policy, the federal government will retain its moral authority and political clout, which it was rapidly losing, to make sure the provinces respect the CHA.

The absence of national standards for the social programs formerly funded under CAP, however, raises fears of a budget rearrangement favouring institutions instead of beneficiaries. For example, the provinces might be tempted to cut income security programs and reallocate the money to the health care system, a sector for which there are national standards. It must be borne in mind, however, that people's health does not begin on admission to hospital.

PARLIAMENTARY ACTION

The federal government has long participated in the financing of provincial programs for health, post-secondary education and public assistance. Federal transfers for health under the EPF and application of *Canada Health Act* criteria have contributed to the creation of a universal and fair public health insurance plan in every province. Observers believe that these plans may be dismantled when the CHST comes into force.

The decrease in federal transfer payments provided for under the CHST and, possibly, the further reductions in the event of failure to comply with the Act, will inevitably translate into difficult political and budgetary choices at the provincial level among the health, post-secondary education and social programs sectors. At the federal level, the government will have to be open in confirming its commitment to national standards or, on the contrary, acknowledge that it no longer has the financial means to enforce the criteria that have defined the Canadian health insurance system since 1984.

The CHST is an interim measure and the federal government has already indicated that it intends to conduct consultations with the governments of all the provinces on possible options for the future of this program in order to better define its political and financial commitment in the area of health and social programs. Given the unilateral nature of the federal governments changes to transfer payments in the last decade, some observers doubt that such federal-provincial consultations would really be very productive. As Ronald H. Neumann reminded us in 1993, federalism is a partnership; negotiation, not unilateralism should be the order of the day.

CHRONOLOGY

22 June 1995 - Bill C-76, establishing the Canada Health and Social Transfer (CHST), received Royal Assent.

20 June 1996 - Bill C-31, establishing the amount and provincial allocation of the CHST for 1997-1998 through 2002-2003, received Royal Assent.

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